

AMENDED IN SENATE JUNE 12, 2006

AMENDED IN ASSEMBLY MAY 2, 2006

AMENDED IN ASSEMBLY APRIL 6, 2006

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

## ASSEMBLY BILL

**No. 2889**

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**Introduced by Assembly Member Frommer**

February 24, 2006

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An act to ~~amend Section 1366.35 of~~ *add Section 1374.18* to the Health and Safety Code, and to ~~amend Section 10785 of~~ *add Section 10119.1* to the Insurance Code, relating to health care coverage.

### LEGISLATIVE COUNSEL'S DIGEST

AB 2889, as amended, Frommer. Health care coverage: ~~federally eligible defined individual market.~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are ~~prohibited from declining to cover or enroll a federally eligible defined individual, except as specified, and are also prohibited from imposing a preexisting condition exclusion with respect to such a person. Existing law defines a federally eligible defined individual, in part, as an individual who has had 18 months of creditable coverage, with the most recent coverage being under a group plan or specified governmental or church plan required to include specified coverage provisions in their plan contracts and policies.~~

~~This bill would expand the definition of a federally eligible defined individual to include an individual who has had 18 months of creditable coverage, with the most recent coverage being under an individual health plan, as specified~~ *require a health care service plan and a health insurer to permit an individual who has been covered for at least 18 months under an individual plan contract issued by the health care service plan or an individual health benefit plan issued by the insurer to transfer, without medical underwriting, as defined, to another individual plan contract or individual health benefit plan having an equal or greater share-of-cost offered by the health care service plan or insurer.*

~~Because the bill, by expanding this definition, would prohibit a plan from denying coverage or enrollment to a larger group of persons, it would make additional conduct unlawful~~ *would specify additional requirements under the Knox-Keene Act, thereby imposing the violation of which could be a crime, it would impose a state-mandated local program.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1     SECTION 1. Section 1374.18 is added to the Health and
- 2     Safety Code, to read:
- 3     1374.18. (a) This section shall apply to a health care service
- 4     plan that provides coverage under an individual plan contract
- 5     that is issued, amended, delivered, or renewed on or after
- 6     January 1, 2007.
- 7     (b) The health care service plan shall permit an individual
- 8     who has been covered for at least 18 months under an individual
- 9     plan contract to transfer, without medical underwriting, as
- 10    defined in subdivision (c), to any other individual plan contract
- 11    offered by that same health care service plan that provides equal
- 12    or lesser benefits, as defined in subdivision (c).

1 (c) The following definitions apply for the purposes of this  
2 section:

3 (1) "Equal or lesser benefits" means that the new individual  
4 plan contract requires an equal or greater share-of-cost from the  
5 individual than the individual plan contract from which the  
6 individual transferred.

7 (2) "Without medical underwriting" means that the health  
8 care service plan shall not decline to offer coverage to, or deny  
9 enrollment of, the individual or impose any preexisting condition  
10 exclusion on the individual.

11 SEC. 2. Section 10119.1 is added to the Insurance Code, to  
12 read:

13 10119.1. (a) This section shall apply to a health insurer that  
14 covers hospital, medical, or surgical expenses under an  
15 individual health benefit plan, as defined in subdivision (a) of  
16 Section 10198.6, that is issued, amended, renewed, or delivered  
17 on or after January 1, 2007.

18 (b) A health insurer shall permit an individual who has been  
19 covered for at least 18 months under an individual health benefit  
20 plan to transfer, without medical underwriting, as defined in  
21 subdivision (c), to any other individual health benefit plan  
22 offered by that same health insurer that provides equal or lesser  
23 benefits, as defined in subdivision (c).

24 (c) The following definitions apply for the purposes of this  
25 section:

26 (1) "Equal or lesser benefits" means that the new individual  
27 health benefit plan requires an equal or greater share-of-cost  
28 from the individual than the individual health benefit plan from  
29 which the individual transferred.

30 (2) "Without medical underwriting" means that the health  
31 insurer shall not decline to offer coverage to, or deny enrollment  
32 of, the individual or impose any preexisting condition exclusion  
33 on the individual.

34 ~~SECTION 1. Section 1366.35 of the Health and Safety Code~~  
35 ~~is amended to read:~~

36 ~~1366.35. (a) A health care service plan providing coverage~~  
37 ~~for hospital, medical, or surgical benefits under an individual~~  
38 ~~health care service plan contract may not, with respect to a~~  
39 ~~federally eligible defined individual desiring to enroll in~~  
40 ~~individual health insurance coverage, decline to offer coverage~~

1 to, or deny enrollment of, the individual or impose any  
2 preexisting condition exclusion with respect to the coverage.

3 (b) For purposes of this section, “federally eligible defined  
4 individual” means an individual who, as of the date on which the  
5 individual seeks coverage under this section, meets all of the  
6 following conditions:

7 (1) Has had 18 or more months of creditable coverage, and  
8 whose most recent prior creditable coverage was under a group  
9 or individual health plan, a federal governmental plan maintained  
10 for federal employees, or a governmental plan or church plan as  
11 defined in the federal Employee Retirement Income Security Act  
12 of 1974 (29 U.S.C. Sec. 1002). For the purposes of this  
13 paragraph, an individual health plan shall not include vision only;  
14 dental only, accident only, specified disease, hospital indemnity;  
15 Medicare supplement, CHAMPUS supplement, long-term care, a  
16 contract or arrangement that provides access to discounted or  
17 reduced rates for health care services or providers but the  
18 individual retains responsibility for full payment of the  
19 discounted rates, or disability income insurance.

20 (2) Is not eligible for coverage under a group health plan,  
21 Medicare, or Medi-Cal, and does not have other health insurance  
22 coverage.

23 (3) Was not terminated from his or her most recent creditable  
24 coverage due to nonpayment of premiums or fraud.

25 (4) If offered continuation coverage under COBRA or  
26 Cal-COBRA, has elected and exhausted that coverage.

27 (e) Every health care service plan shall comply with applicable  
28 federal statutes and regulations regarding the provision of  
29 coverage to federally eligible defined individuals, including any  
30 relevant application periods.

31 (d) A health care service plan shall offer the following health  
32 benefit plan contracts under this section that are designed for,  
33 made generally available to, are actively marketed to, and enroll,  
34 individuals: (1) either the two most popular products as defined  
35 in Section 300gg-41(e)(2) of Title 42 of the United States Code  
36 and Section 148.120(e)(2) of Title 45 of the Code of Federal  
37 Regulations or (2) the two most representative products as  
38 defined in Section 300gg-41(e)(3) of the United States Code and  
39 Section 148.120(e)(3) of Title 45 of the Code of Federal  
40 Regulations, as determined by the plan in compliance with

1 ~~federal law. A health care service plan that offers only one health~~  
2 ~~benefit plan contract to individuals, excluding health benefit~~  
3 ~~plans offered to Medi-Cal or Medicare beneficiaries, shall be~~  
4 ~~deemed to be in compliance with this article if it offers that~~  
5 ~~health benefit plan contract to federally eligible defined~~  
6 ~~individuals in a manner consistent with this article.~~

7 ~~(e) (1) In the case of a health care service plan that offers~~  
8 ~~health insurance coverage in the individual market through a~~  
9 ~~network plan, the plan may do both of the following:~~

10 ~~(A) Limit the individuals who may be enrolled under that~~  
11 ~~coverage to those who live, reside, or work within the service~~  
12 ~~area for the network plan.~~

13 ~~(B) Within the service area of the plan, deny coverage to~~  
14 ~~individuals if the plan has demonstrated to the director that the~~  
15 ~~plan will not have the capacity to deliver services adequately to~~  
16 ~~additional individual enrollees because of its obligations to~~  
17 ~~existing group contractholders and enrollees and individual~~  
18 ~~enrollees, and that the plan is applying this paragraph uniformly~~  
19 ~~to individuals without regard to any health status-related factor of~~  
20 ~~the individuals and without regard to whether the individuals are~~  
21 ~~federally eligible defined individuals.~~

22 ~~(2) A health care service plan, upon denying health insurance~~  
23 ~~coverage in any service area in accordance with subparagraph~~  
24 ~~(B) of paragraph (1), may not offer coverage in the individual~~  
25 ~~market within that service area for a period of 180 days after the~~  
26 ~~coverage is denied.~~

27 ~~(f) (1) A health care service plan may deny health insurance~~  
28 ~~coverage in the individual market to a federally eligible defined~~  
29 ~~individual if the plan has demonstrated to the director both of the~~  
30 ~~following:~~

31 ~~(A) The plan does not have the financial reserves necessary to~~  
32 ~~underwrite additional coverage.~~

33 ~~(B) The plan is applying this subdivision uniformly to all~~  
34 ~~individuals in the individual market and without regard to any~~  
35 ~~health status-related factor of the individuals and without regard~~  
36 ~~to whether the individuals are federally eligible defined~~  
37 ~~individuals.~~

38 ~~(2) A health care service plan, upon denying individual health~~  
39 ~~insurance coverage in any service area in accordance with~~  
40 ~~paragraph (1), may not offer that coverage in the individual~~

1 market within that service area for a period of 180 days after the  
2 date the coverage is denied or until the issuer has demonstrated to  
3 the director that the plan has sufficient financial reserves to  
4 underwrite additional coverage, whichever is later.

5 (g) The requirement pursuant to federal law to furnish a  
6 certificate of creditable coverage shall apply to health insurance  
7 coverage offered by a health care service plan in the individual  
8 market in the same manner as it applies to a health care service  
9 plan in connection with a group health benefit plan.

10 (h) A health care service plan shall compensate a life agent or  
11 fire and casualty broker-agent whose activities result in the  
12 enrollment of federally eligible defined individuals in the same  
13 manner and consistent with the renewal commission amounts as  
14 the plan compensates life agents or fire and casualty  
15 broker-agents for other enrollees who are not federally eligible  
16 defined individuals and who are purchasing the same individual  
17 health benefit plan contract.

18 (i) Every health care service plan shall disclose as part of its  
19 COBRA or Cal-COBRA disclosure and enrollment documents,  
20 an explanation of the availability of guaranteed access to  
21 coverage under the Health Insurance Portability and  
22 Accountability Act of 1996, including the necessity to enroll in  
23 and exhaust COBRA or Cal-COBRA benefits in order to become  
24 a federally eligible defined individual.

25 (j) No health care service plan may request documentation as  
26 to whether or not a person is a federally eligible defined  
27 individual other than is permitted under applicable federal law or  
28 regulations.

29 (k) This section shall not apply to coverage defined as  
30 excepted benefits pursuant to Section 300gg(c) of Title 42 of the  
31 United States Code.

32 (l) This section shall apply to health care service plan contracts  
33 offered, delivered, amended, or renewed on or after January 1,  
34 2001.

35 SEC. 2. Section 10785 of the Insurance Code is amended to  
36 read:

37 10785. (a) A health insurer that covers hospital, medical, or  
38 surgical expenses under an individual health benefit plan as  
39 defined in subdivision (a) of Section 10198.6 may not, with  
40 respect to a federally eligible defined individual desiring to enroll

1 in individual health insurance coverage, decline to offer coverage  
2 to, or deny enrollment of, the individual or impose any  
3 preexisting condition exclusion with respect to the coverage.

4 (b) For purposes of this section, “federally eligible defined  
5 individual” means an individual who, as of the date on which the  
6 individual seeks coverage under this section, meets all of the  
7 following conditions:

8 (1) Has had 18 or more months of creditable coverage, and  
9 whose most recent prior creditable coverage was under a group  
10 or individual health plan, a federal governmental plan maintained  
11 for federal employees, or a governmental plan or church plan as  
12 defined in the federal Employee Retirement Income Security Act  
13 of 1974 (29 U.S.C. Sec. 1002). For the purposes of this  
14 paragraph, an individual health plan shall not include vision only,  
15 dental only, accident only, specified disease, hospital indemnity,  
16 Medicare supplement, CHAMPUS supplement, long-term care, a  
17 contract or arrangement that provides access to discounted or  
18 reduced rates for health care services or providers but the  
19 individual retains responsibility for full payment of the  
20 discounted rates, or disability income insurance.

21 (2) Is not eligible for coverage under a group health plan,  
22 Medicare, or Medi-Cal, and does not have other health insurance  
23 coverage.

24 (3) Was not terminated from his or her most recent creditable  
25 coverage due to nonpayment of premiums or fraud.

26 (4) If offered continuation coverage under COBRA or  
27 Cal-COBRA, has elected and exhausted that coverage.

28 (c) Every health insurer that covers hospital, medical, or  
29 surgical expenses shall comply with applicable federal statutes  
30 and regulations regarding the provision of coverage to federally  
31 eligible defined individuals, including any relevant application  
32 periods.

33 (d) A health insurer shall offer the following health benefit  
34 plans under this section that are designed for, made generally  
35 available to, are actively marketed to, and enroll, individuals:

36 (1) either the two most popular products as defined in Section  
37 300gg-41(e)(2) of Title 42 of the United States Code and Section  
38 148.120(e)(2) of Title 45 of the Code of Federal Regulations or  
39 (2) the two most representative products as defined in Section  
40 300gg-41(e)(3) of the United States Code and Section

1 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as  
2 determined by the insurer in compliance with federal law. An  
3 insurer that offers only one health benefit plan to individuals,  
4 excluding health benefit plans offered to Medi-Cal or Medicare  
5 beneficiaries, shall be deemed to be in compliance with this  
6 chapter if it offers that health benefit plan contract to federally  
7 eligible defined individuals in a manner consistent with this  
8 chapter.

9 (e) (1) In the case of a health insurer that offers health benefit  
10 plans in the individual market through a network plan, the insurer  
11 may do both of the following:

12 (A) Limit the individuals who may be enrolled under that  
13 coverage to those who live, reside, or work within the service  
14 area for the network plan.

15 (B) Within the service area covered by the health benefit plan,  
16 deny coverage to individuals if the insurer has demonstrated to  
17 the commissioner that the insured will not have the capacity to  
18 deliver services adequately to additional individual insureds  
19 because of its obligations to existing group policyholders, group  
20 contractholders and insureds, and individual insureds, and that  
21 the insurer is applying this paragraph uniformly to individuals  
22 without regard to any health status-related factor of the  
23 individuals and without regard to whether the individuals are  
24 federally eligible defined individuals.

25 (2) A health insurer, upon denying health insurance coverage  
26 in any service area in accordance with subparagraph (B) of  
27 paragraph (1), may not offer health benefit plans through a  
28 network in the individual market within that service area for a  
29 period of 180 days after the coverage is denied.

30 (f) (1) A health insurer may deny health insurance coverage in  
31 the individual market to a federally eligible defined individual if  
32 the insurer has demonstrated to the commissioner both of the  
33 following:

34 (A) The insurer does not have the financial reserves necessary  
35 to underwrite additional coverage.

36 (B) The insurer is applying this subdivision uniformly to all  
37 individuals in the individual market and without regard to any  
38 health status-related factor of the individuals and without regard  
39 to whether the individuals are federally eligible defined  
40 individuals.



1     ~~(2) A health insurer, upon denying individual health insurance~~  
2 ~~coverage in any service area in accordance with paragraph (1);~~  
3 ~~may not offer that coverage in the individual market within that~~  
4 ~~service area for a period of 180 days after the date the coverage is~~  
5 ~~denied or until the insurer has demonstrated to the commissioner~~  
6 ~~that the insurer has sufficient financial reserves to underwrite~~  
7 ~~additional coverage, whichever is later.~~

8     ~~(g) The requirement pursuant to federal law to furnish a~~  
9 ~~certificate of creditable coverage shall apply to health benefit~~  
10 ~~plans offered by a health insurer in the individual market in the~~  
11 ~~same manner as it applies to an insurer in connection with a~~  
12 ~~group health benefit plan policy or group health benefit plan~~  
13 ~~contract.~~

14     ~~(h) A health insurer shall compensate a life agent or fire and~~  
15 ~~casualty broker-agent whose activities result in the enrollment of~~  
16 ~~federally eligible defined individuals in the same manner and~~  
17 ~~consistent with the renewal commission amounts as the insurer~~  
18 ~~compensates life agents or fire and casualty broker-agents for~~  
19 ~~other enrollees who are not federally eligible defined individuals~~  
20 ~~and who are purchasing the same individual health benefit plan.~~

21     ~~(i) Every health insurer shall disclose as part of its COBRA or~~  
22 ~~Cal-COBRA disclosure and enrollment documents, an~~  
23 ~~explanation of the availability of guaranteed access to coverage~~  
24 ~~under the Health Insurance Portability and Accountability Act of~~  
25 ~~1996, including the necessity to enroll in and exhaust COBRA or~~  
26 ~~Cal-COBRA benefits in order to become a federally eligible~~  
27 ~~defined individual.~~

28     ~~(j) No health insurer may request documentation as to whether~~  
29 ~~or not a person is a federally eligible defined individual other~~  
30 ~~than is permitted under applicable federal law or regulations.~~

31     ~~(k) This section shall not apply to coverage defined as~~  
32 ~~excepted benefits pursuant to Section 300gg(c) of Title 42 of the~~  
33 ~~United States Code.~~

34     ~~(l) This section shall apply to policies or contracts offered,~~  
35 ~~delivered, amended, or renewed on or after January 1, 2001.~~

36     SEC. 3. No reimbursement is required by this act pursuant to  
37 Section 6 of Article XIII B of the California Constitution because  
38 the only costs that may be incurred by a local agency or school  
39 district will be incurred because this act creates a new crime or  
40 infraction, eliminates a crime or infraction, or changes the

- 1 penalty for a crime or infraction, within the meaning of Section
- 2 17556 of the Government Code, or changes the definition of a
- 3 crime within the meaning of Section 6 of Article XIII B of the
- 4 California Constitution.

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